



Founder of
**BIG HORN BASIN
 ORTHOPAEDIC
 CLINIC, P.C.**



Founder of
**YELLOWSTONE
 SPORTS MEDICINE
 L.L.C.**

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Sleep Health Questionnaire

Your sleep health is very important to us. Help us to manage your surgery and recovery by completing the 7 questions below.

Height _____ in Weight _____ lb Age _____ Male/Female BMI _____ (from chart on back of page)

1.) Snoring:

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

YES NO

2.) Tired:

Do you often feel tired, fatigued or sleepy during daytime?

YES NO

3.) Observed:

Has anyone observed you stop breathing during your sleep?

YES NO

4.) Blood pressure:

Do you have or are you being treated for high blood pressure?

YES NO

5.) BMI:

Is your BMI more than 35kg/m?

YES NO

6.) Age:

Age over 50 yrs old?

YES NO

7.) Gender:

Gender Male?

YES NO

TOTAL NUMBER OF YES ANSWERS: _____

(High: >3, Low: <3)

PRINT _____ SIGNATURE _____ DATE _____